Medical Fee Schedule Dispute Request Form

Virginia Workers' Compensation Commission

Jurisdiction Claim Number (JCN)

Claim Administrator Number

Dispute Request

Name of Contacting Party

Title

Mailing Address

Email Address

Primary Phone

Dispute Information

Other Party Involved in Dispute

Other Party Primary Phone

Name of Injured Worker

Date of Injury

Name of Employer

Date of Service

Issue(s) in Dispute (Check all that apply):

- ☐ CPT
- ☐ Ground Rule Reference
- ☐ PPO Contract w/Medical Fee Schedule Component
- ☐ Supply
- ☐ Other: _____

Dollar Amount in Dispute:

Payment you received _____ Payment you feel you should have received _____

Please provide a detailed explanation of the dispute:

_____

_____

Please attach the three required supporting documents that are applicable in your dispute:

- Original and Resubmitted Bill(s)
- Explanation of Reimbursement/Benefit
- Supporting Documentation

☐ Correspondence and/or Specific Information Regarding the Dispute (Optional - Check box if attached)

This Dispute Resolution process shall be subject to the prompt payment or limitation of claims provisions of Va. Code Section 65.2-605.1.